INSURANCE

Budget Summary

Fund	2000-01 Base Year Doubled	2001-03 Governor	2001-03 Jt. Finance	2001-03 Legislature	2001-03 Act 16	Act 16 Change Over Base Year Doubled Amount	Percent
PR	$29,241,800	$32,202,600	$32,151,200	$32,151,200	$32,151,200	$2,909,400	9.9%
SEG	138,734,800	153,546,100	153,522,500	153,522,500	153,522,500	14,787,700	10.7
TOTAL	$167,976,600	$185,748,700	$185,673,700	$185,673,700	$185,673,700	$17,697,100	10.5%

FTE Position Summary

Fund	2000-01 Base	2002-03 Governor	2002-03 Jt. Finance	2002-03 Legislature	2002-03 Act 16	Act 16 Change Over 2000-01 Base
PR	120.25	121.25	121.25	121.25	121.25	1.00
SEG	13.75	13.75	13.75	13.75	13.75	0.00
TOTAL	134.00	135.00	135.00	135.00	135.00	1.00

Budget Change Items

1. STANDARD BUDGET ADJUSTMENTS [LFB Paper 540]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
PR	- $1,101,800	$0	- $1,101,800
SEG	25,000	- 23,600	1,400
Total	- $1,076,800	- $23,600	- $1,100,400

Governor: Delete a net amount of $538,400 (-$550,900 PR and $12,500 SEG) for the following: (a) turnover reduction (-$119,100 PR annually); (b) remove noncontinuing funding (-$765,200 PR annually); (c) full funding of salaries and fringe benefits ($296,100 PR and $10,000 SEG annually); (d) BadgerNet increases ($1,800 PR annually); and (e) fifth week of vacation as cash ($35,500 PR and $2,500 SEG annually). In addition, transfer $50,900 ($16,800 PR and $34,100 SEG) annually from unallotted reserve to supplies and services.

Joint Finance/Legislature: Reduce funding by $11,800 SEG annually to eliminate one-time funding and to reflect the amount of ongoing segregated funds needed to support the imaging of state life insurance files ($22,300 annually).

2. INFORMATION TECHNOLOGY -- REPLACE HARDWARE AND SOFTWARE

PR	$1,165,600
SEG	61,000
Total	$1,226,600

Governor/Legislature: Provide $613,300 ($582,800 PR and $30,500 SEG) annually to increase funding for the scheduled replacement of the agency's current inventory of hardware and software. The bill includes $291,400 PR annually for OCI's administrative and support services appropriation to reflect that these costs are assessed to OCI's general PR program operation budget on a charge-back basis and therefore, "double-counted" in the agency's budget.

3. RENT AND MOVING EXPENSES

PR	$1,022,200
SEG	63,200
Total	$1,085,400

Governor/Legislature: Provide $381,900 ($359,600 PR and $22,300 SEG) in 2001-02 and $703,500 ($662,600 PR and $40,900 SEG) in 2002-03 to fund moving expenses and costs associated with renting additional space. The administration anticipates that OCI will move to GEF 3, an existing state office building in Madison, in January, 2002. This item includes $179,800 PR in 2001-02 and $331,300 PR in 2002-03 in the agency's administrative and support services appropriation to reflect that these costs would be charged to the appropriate programs and therefore, "double-counted" in the agency's budget.

4. INFORMATION TECHNOLOGY -- PROGRAMMING SERVICES [LFB Paper 541]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
PR	$767,200	- $42,600	$724,600

Governor: Provide $354,200 in 2001-02 and $413,000 in 2002-03 to fund applications development services. The funding budgeted in the agency's general program operations budget to support these costs ($177,100 in 2001-02 and $206,500 in 2002-03) is equivalent to the estimated costs of supporting 3.0 state positions, beginning in 2001-02, to provide these programming services. The administration indicates that OCI would purchase these programming services from the Department of Electronic Government, which would be created in the bill. The bill would increase OCI's administrative and support services appropriation to reflect that these costs would be assessed to OCI's general PR program operations budget on a charge-back basis and therefore, "double-counted" in the agency's budget.

Joint Finance/Legislature: Modify the Governor's recommendation to: (a) provide that if the Governor's recommendation to create a new Department of Electronic Government, or

comparable proposal for the provision of centralized information technology services to state agencies is not approved, OCI would be authorized 3.0 additional programmer positions, beginning in 2001-02; (b) provide that the funding would be one-time, and that if positions are approved, they would be two-year project positions; and (c) reduce funding by $42,600 in 2001-02 to eliminate one-time funds included in the bill for permanent property to reflect that the current contracted programming staff have equipment that could be used by new contractors or staff.

5. FINANCIAL EXAMINATIONS -- CPA ASSISTANCE AND EXAMINER TRAINING

PR	$356,300

Governor/Legislature: Provide $178,500 in 2001-02 and $177,800 in 2002-03 in one-time funding to support assistance with financial examinations and training. The bill provides: (a) $160,000 annually for OCI to contract with certified public accounting firms to assist with financial examinations of insurance companies as new OCI staff are being trained; and (b) $18,500 in 2001-02 and $17,800 in 2002-03 to increase training for new and experienced examiners.

6. SEMI-AUTOMATIC PAY PROGRESSIONS

PR	$346,500

Governor/Legislature: Provide $144,200 in 2001-02 and $202,300 in 2002-03 to fund semi-automatic pay progressions and raised minimum rates for insurance financial examiners, as authorized in the latest bargaining contract and by the Department of Employment Relations (DER). Under the contract, effective December 31, 2000, insurance financial examiners are eligible for pay increases every six months, based on their seniority, up to a certain level of pay. In addition, DER has authorized increases in minimum rates to assist OCI in hiring examiners.

7. ADMINISTRATIVE SERVICES CHARGES

PR	$133,600
SEG	205,000
Total	$338,600

Governor/Legislature: Provide $169,300 ($66,800 PR and $102,500 SEG) annually to fund increased costs of services provided by the Division of Administrative Services to other OCI programs. The bill provides $66,800 PR annually to reflect pay plan adjustments for staff in the Division of Administrative Services. In addition, the bill would provide $102,500 SEG annually to fund increases in administrative costs assessed to the patients compensation fund ($77,200 SEG), the state life insurance fund ($500 SEG) and the local government property insurance fund ($24,800 SEG). OCI administrative services are provided on a charge-back basis, and are therefore, "double-counted" in the agency's budget.

8. INSURANCE EXAMINER FOR MARKET REGULATION

	Funding	Positions
PR	$86,900	1.00

Governor/Legislature: Provide $42,900 in 2001-02 and $44,000 in 2002-03 to support 1.0 insurance examiner position, beginning in 2001-02, for the Bureau of Market Regulation. The position would evaluate the use of the Internet in marketing, sales and customer service in the insurance industry and, to a lesser extent, help the Bureau meet increased workload relating to property and casualty insurance issues. OCI currently has 21.0 FTE insurance examiners. The funding includes $3,100 in 2001-02 and $600 in 2002-03 for information technology costs that are assessed to OCI's general PR program operations budget on a charge-back basis and therefore, "double-counted" in the agency's budget.

9. MEDIGAP HELPLINE [LFB Paper 542]

	Governor (Chg. to Base)	Jt. Finance/Leg. (Chg. to Gov)	Net Change
PR	$69,600	- $8,800	$60,800

Governor: Provide $31,600 in 2001-02 and $38,000 in 2002-03 to increase funding for the Medigap helpline administered by the Board on Aging and Long-Term Care. The Board's staff provide information and counseling on Medicare supplemental insurance, long-term care insurance and medical assistance to persons who call the toll-free helpline. The helpline is supported from insurance revenues collected by OCI and transferred to the Board.

Joint Finance/Legislature: Reduce funding by $4,400 annually to reflect the actual level of expenditures authorized under the bill for the Board to operate the Medigap helpline.

10. CONSUMER EDUCATION MATERIALS

PR	$67,100

Governor/Legislature: Provide $33,100 in 2001-02 and $34,000 in 2002-03 to increase funding for consumer education materials. OCI distributed over 117,400 copies of brochures, pamphlets and booklets in 1999-00. This funding is intended to enable OCI to maintain its current distribution level, develop new publications and begin developing and distributing publications in Spanish. The funding includes $8,800 annually in postage costs which are assessed to OCI's PR general program operations appropriation on a charge-back basis and therefore, "double-counted" in the agency's budget.

11. POSTAGE

PR	$47,600
SEG	600
Total	$48,200

Governor/Legislature: Provide $24,100 ($23,800 PR and $300 SEG) annually to fund increased postage costs resulting from the January, 2001, increases in postage rates.

12. LOCAL GOVERNMENT PROPERTY INSURANCE FUND

SEG	$14,394,500

Governor/Legislature: Provide $6,141,900 in 2001-02 and $8,252,600 in 2002-03 to reflect a reestimate of operational and contractual administrative expenses associated with the local government property insurance fund (LGPIF). The LGPIF offers property insurance for tax-supported local government property, such as government buildings, schools and libraries. The bill would provide $6,097,400 in 2001-02 and $8,183,800 in 2002-03 to reflect a reestimate of operational costs related to claims and loss expenses, dividend payouts, rating bureau assessments and reinsurance costs. In addition, the bill would provide $44,500 in 2001-02 and $68,800 in 2002-03 to fund projected increases in contractual expenses resulting from increased administrative costs, such as underwriting, rating and policy issuance, claims and loss adjustment administration and dividend distribution payouts. OCI indicates that the LGPIF is insuring more policyholders at higher replacement values, resulting in greater loss payouts and higher administrative expenses.

13. STATE LIFE INSURANCE FUND -- FINANCIAL MANAGEMENT SYSTEM

SEG	$62,000

Governor/Legislature: Provide $56,000 in 2001-02 and $6,000 in 2002-03 to purchase a new insurance financial management system for the state life insurance fund (SLIF). The SLIF provides low-cost life insurance coverage of up to $10,000 to residents of Wisconsin. The new system is intended to address Legislative Audit Bureau recommendations that OCI perform monthly reconciliations with WISMART, comply with National Association of Insurance Commissioners mandated accounting standards and allow for a more complete set of financial records to assist in financial audits.

14. TREATMENT OF CERTAIN REVENUES [LFB Paper 543]

Governor: Specify that 90% of the revenues OCI collects to pay for: (a) expenses involved in the conversion of a domestic mutual into a stock corporation; and (b) reasonable costs incurred by OCI in employing experts to assist with industry examinations or reviews be deposited to the agency's PR general program operations appropriation. The remaining 10% of these revenues would be deposited to the general fund as GPR-earned revenues.

Current law specifies that 90% of revenue from various licenses and other fees charged by OCI, fees paid by examinees to pay for the costs of OCI examination expenses and publication sales be credited to this appropriation. However, the statutes do not make specific references to the treatment of revenues derived from these conversions or fees charged for experts to assist with industry examinations and reviews. Under current practice, OCI deposits 90% of the revenue from expert fees and 100% of the revenue it assesses to cover the cost of conversions of domestic mutuals into stock corporations to the PR general program operations appropriation. Consequently, the bill would require OCI to charge approximately 111.1% of its

expenses relating to these conversions, of which 90% would be deposited to the agency's PR general program operations appropriation to fund 100% of the agency's expenses relating to the conversion.

Joint Finance/Legislature: Modify the Governor's recommendation to specify that 90% of revenues that OCI collects to pay for expenses involved in all types of conversions for which OCI receives reimbursement be credited to the agency's program revenue general operations appropriation. The remaining 10% of these revenues would be deposited to the general fund.

[Act 16 Sections: 462 and 462c]

15. AUTHORITY TO SET FEES BY RULE [LFB Paper 544]

Governor: Authorize the Commissioner to establish, by rule, fees paid to OCI that are currently established by statute. Specify that a rule promulgated for current statutory fees may provide for a maximum fee amount, and that the Commissioner could charge a lesser amount than the maximum fee amount specified in rule. Provide that the statutory fees would apply unless the Commissioner specifies, by rule, different fees. Eliminate statutory maximum amounts for certain fees that OCI may, under current law, establish by rule.

OCI fees include licensing fees, filing fees, listing fees, fees assessed for the preparation and furnishing of specified documents and fees assessed for certified copies of OCI documents. Revenues from insurance fees support OCI's general operations, except costs relating to examinations of insurance companies and management of segregated funds. As under current law, the Commissioner would be authorized to increase fees if the statutory fees, or fees established by rule, are insufficient to support OCI services.

Joint Finance/Legislature: Delete provision.

16. ANNUAL REPORT

Governor/Legislature: Eliminate the current requirement that the Commissioner have sufficient copies of the annual report printed to meet all requests for copies. Instead, require the Commissioner to have the report published in sufficient quantity to meet all requests. The modification would allow the report to be provided electronically, as well as in printed form. The price of the report is determined by the Commissioner.

[Act 16 Section: 3735]

17. JOINT PROVISION OF HEALTH CARE BENEFITS BY POLITICAL SUBDIVISIONS

Joint Finance/Legislature: Allow any political subdivision (defined as any city, village, town or county) and one or more other political subdivision, that together have at least 100

employees, to jointly provide health care benefits on a self-insured basis. The coverage would be subject to current statutory requirements that apply to self-insured health plans of a city, village or town and to counties that currently provide joint coverage.

Under current law, a city, village, town, county or school district may provide health care benefits to its officers and employees on a self-insured basis, subject to certain requirements. In addition, two or more counties, or two or more school districts, that together have at least 100 employees, may jointly provide health insurance on a self-insured basis.

The extension to allow any political subdivisions, that together have more than 100 employees, to join to provide self-insured health care benefits, would first apply to employees who are covered by a collective bargaining agreement upon the expiration, extension, renewal or modification of the agreement.

[Act 16 Sections: 2001q, 2003r, 2014m, 2014n, 3143m, 3733r, 3761r and 9359(3mk)]

18. COVERAGE OF CONTRACEPTIVE ARTICLES AND SERVICES

Senate: Require every health insurance policy, including managed care plans, health care plans offered by the state and every self-insured health plan of a school district, county, city or village to provide coverage for contraceptive articles and services if the policy or plan covers outpatient health care services, preventive treatments and services or prescription drugs and devices.

Define contraceptive articles as any of the following: (a) a drug, medicine, mixture, preparation, instrument, article or device of any nature that is approved by the Federal Food and Drug Administration (FDA) for use to prevent pregnancy, that is prescribed by a licensed health care provider to prevent pregnancy and that may not be obtained without a prescription; and (b) a hormonal compound that is taken orally and that is approved by the FDA for use to prevent pregnancy. Specify that a contraceptive article would not include any drug, medicine, mixture, preparation, instrument, article or device of any nature prescribed for use in terminating the pregnancy of a woman who is known by the prescribing licensed health care provider to be pregnant.

Require coverage for all of the following: (a) contraceptive articles; (b) medical services, including counseling and physical examinations, for the prescription or use of a contraceptive article or of a procedure to prevent pregnancy; and (c) medical procedures performed to prevent a pregnancy. Specify that coverage may be subject to exclusions or limitations, including copayments and deductibles, that apply generally to the benefits that are provided under the policy or self-insured health plan.

Specify that the coverage requirements would not apply to: (a) a disability insurance policy that covers only specific diseases; (b) a health care plan offered by a limited service health organization, or by a provider plan that is not a managed care plan; (c) a Medicare replacement

policy, Medicare supplement policy or a long-term care insurance policy; or (d) a disability insurance policy that is issued to a religious employer, if the employer requests that the insurer issuing the policy not provide coverage for contraceptive articles and services on the basis that the articles and services covered are contrary to the religious employer's religious tenets. A religious employer that requests that contraceptive coverage not be covered would be required to provide written notice to a prospective insured person under the policy, prior to the person's coverage, that specifies the articles and services that would not be covered.

Specify that the provision would take effect on the first day of the sixth month beginning after publication of the bill, and would apply to policies that are issued, renewed or established on that date.

Conference Committee/Legislature: Delete provision.

19. ELIMINATE POINT- OF- SERVICE OPTION PLAN REQUIREMENT

Assembly: Delete the requirement that employers with 25 or more full-time employees that offer their employees a health maintenance organization (HMO) or preferred provider plan that provides comprehensive health care services also offer a point-of-service (POS) option plan. A POS option plan allows a person enrolled in an HMO or a preferred provider plan to obtain health services from a provider that is not participating in the HMO or preferred provider plan, provided that: (1) the nonparticipating provider holds a license or certificate that authorizes or qualifies the provider to provide the services; (2) the amount paid to the nonparticipating provider is limited to the amount that would be paid for those services under the HMO or preferred provider plan; and (3) the enrollee pays any additional costs or charges related to the coverage.

Under provisions enacted in 1999 Wisconsin Act 9, employers with 25 or more full-time employees that offer HMOs or preferred provider plans must also offer a POS option plan. The Insurance Commissioner is required to promulgate rules to administer the requirement. This requirement took effect April 1, 2001.

Conference Committee/Legislature: Delete provision.

20. EXPANSION OF INDEPENDENT REVIEW PROCEDURE

Senate: Expand the applicability of the independent review procedure to include the following types of coverage: (a) coverage that is only accident or disability insurance, or any combination of the two types; (b) coverage issued as a supplement to liability insurance; (c) liability insurance, including general liability insurance and automobile liability insurance; and (d) automobile medical payment insurance. The independent review procedure refers to instances in which an insured may have certain denials of coverage by a health plan independently reviewed by one or more health care providers not associated with the plan

under which coverage was denied. The reviews apply to coverage for treatment that will exceed $250, and that is determined by the plan to be experimental or as not meeting the plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness. The procedure currently applies to hospital or medical policies generally, but excludes accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, worker's compensation, automobile medical payment insurance, credit only insurance, coverage for on-site medical clinics, separate policies for limited benefits, such as dental or vision, long-term care or nursing home care and medical supplement insurance.

Conference Committee/Legislature: Delete provision.

21. MANAGED CARE AND PREFERRED PROVIDER PLANS

Assembly/Legislature: Replace all current statutory references to "managed care plans" with references to "defined network plans." Require defined network plans to include a sufficient number and sufficient types of qualified providers to meet the anticipated needs of its enrollees with respect to covered benefits and normal practices and standards in the geographic area. Under current law, managed care plans must include a sufficient number, and sufficient types, of providers to meet anticipated needs with respect to covered benefits. Require defined network plans or, if specified under contract, a provider, to notify all plan enrollees of continuity of care provisions whenever a participating provider terminates participation in a plan. Continuity of care refers to requirements for plans to provide coverage of providers' services under certain circumstances, if the plan represented that the provider was or would be a participating provider in marketing materials provided to enrollees.

Change the definition of a preferred provider plan to specify that a preferred provider plan provides coverage without referral, regardless of whether the health care services are performed by participating or nonparticipating providers.

For preferred provider plans that cover the same services when the services are performed by a nonparticipating provider as a participating provider, make the following modifications: (a) modify access standards to specify that standards relating to adequate choice, primary provider selection, specialist providers and telephone access do not apply to those preferred provider plans; (b) allow those preferred provider plans to contract for services related to clinical protocols and utilization management; (c) require those preferred provider plans to appoint a medical director, who shall be a physician, only to the extent that the plan or its designee assumes responsibility for clinical protocols and utilization management; and (d) require those preferred provider plans to develop procedures for remedying quality of care problems, including written procedures for taking appropriate corrective action.

Specify that preferred provider plans that do not cover the same services when the services are performed by a nonparticipating provider, as when those services are performed by a participating provider, would continue to be subject to current law standards relating to

adequate choice, primary provider selection, specialist providers, telephone access and quality assurance. In addition, they would continue to be required to appoint a physician as medical director who would be responsible for clinical protocols, quality assurance and utilization management policies of the plan.

Allow, instead of require, as provided under current law, the Insurance Commissioner to promulgate rules for preferred provider plans and defined network plans, as appropriate, for the following: (a) to ensure that enrollees are not forced to travel excessive distances to receive health care services; (b) to ensure that the continuity of patient care for enrollees meets statutory continuity of care requirements; (c) to define substantially equivalent coverage of health care expenses; and (d) to ensure that employees offered a health maintenance organization or a preferred provider plan that provides comprehensive services are given adequate notice of the opportunity to enroll, and provided complete and understandable information concerning the differences between the plans, including differences among providers available and differences resulting from special limitations or requirements imposed by an institutional provider, because of its affiliation with a religious organization.

Finally, provide that any rules relating to preferred provider and defined network plans recognize the differences between preferred provider plans and other types of defined network plans, take into account the fact that preferred provider plans provide coverage for the services of nonparticipating providers and be appropriate to the type of plan to which the rules apply.

[Act 16 Sections: 1398wm, 1398y, 3741amc thru 3741xmt, 3763f and 3763g]

22. MOTOR VEHICLE INSURANCE -- NONORIGINAL MANUFACTURER REPLACEMENT PARTS

Senate: Modify laws relating to the use of nonoriginal manufacturer replacement parts in vehicles five years of age or newer to provide that an insurer may not require the use of a nonoriginal manufacturer replacement part in the repair of the insured's motor vehicle, unless the insurer receives authorization from the insured before the part is installed. Replacement parts affected include any nonmechanical sheet metal or plastic parts that generally constitute the exterior of a vehicle.

Specify that authorization could be obtained on a form entitled "Replacement Parts Notice and Authorization Form" that includes: (a) a clear identification of each nonoriginal manufacturer replacement part that will be used in the repair of the insured's motor vehicle if the insured provides authorization for the part's use; (b) a statement that the insured may choose to have replacement parts that are made by or for the manufacturer of the insured's motor vehicle used in the repair of the insured's motor vehicle; (c) a statement that the insurer's obligation to cover repairs to the insured's motor vehicle will not be affected by the insured's choice under (b); (d) a statement that nonoriginal manufacture replacement parts are not covered by the warranty of the manufacturer of the insured's motor vehicle; and (e) two signature lines for the insured's signature, with one line designated as authorizing the use, in

the repair, of nonoriginal manufacturer replacement parts and the other line designating as requiring the use, in the repair, of only replacement parts made by or for the manufacturer of the insured's motor vehicle. Specify that the form would allow the insured to authorize the use of a nonoriginal manufacturer replacement part or to require the use of a replacement part made by or for the manufacturer of the insured's motor vehicle with respect to each replacement part to be used in the repair.

Require that the notice be attached to the repair estimate prepared by the insurer, or be delivered before repairs begin if the insurer approves an estimate obtained by the insured. Prohibit the insurer from requiring the person repairing the vehicle to provide the notice and authorization form. Delete current law provisions that allow the intent to use nonoriginal manufacturer replacement parts in the repair of a motor vehicle that is five years old or newer to be given over the telephone. The provision would not apply to motorcycles, mopeds, semitrailers or trailers designed for the use in combination with a truck or truck tractor.

Under current law, an insurer may not require the use of a nonoriginal manufacturer replacement part in the repair of an insured's motor vehicle, including motorcycles, unless the insurer provides notice of each nonoriginal manufacturer part that is intended to be used in the repair. The notice appears or is attached to the estimate of the cost repair. The insurer must deliver the estimate and notice to the insured prior to the repair, except: (1) if the insured authorizes the repair to begin prior to the approval by the insurer; or (2) if notice of the intent to use nonoriginal manufacturer parts is given by telephone. In these two cases, the notice may be mailed within three working days.

Conference Committee/Legislature: Delete provision.

23. PAYMENT OF INSURANCE CLAIMS FOR MEDICAL OR SURGICAL PROCEDURES

Assembly: Prohibit an insurer from denying payment under an individual or group disability policy or a certificate of group disability insurance policy, for a medical or surgical service or procedure on the basis that the service or procedure is an integral part of a component of a second medical or surgical procedure. Specify that an exception would be provided if, under Medicare Part B, payment for the first service or procedure is included in the payment for the second service or procedure.

Specify that this prohibition would apply to disability insurance policies, which are defined as surgical, medical, hospital, major medical or other health service coverage, but would not include hospital indemnity policies or ancillary coverages such as income continuation, loss of time or accident benefits. Specify that this provision would also apply to health care coverage plans offered by the state, plans offered by the Group Insurance Board, sickness plans offered by cooperative associations, limited service health organizations, preferred provider plans and managed care plans. Provide that this prohibition would not be subject to employer bargaining under Chapter 111 of the statutes.

The provision would first apply to insurance policies that are inconsistent with the provision upon renewal of those policies, and to collective bargaining agreements on the day on which the collective bargaining agreement expires or is extended, modified or renewed.

Conference Committee/Legislature: Delete provision.

24. CLAIMS FOR CHIROPRACTIC SERVICES

Senate/Legislature: Provide that an insurance claim for payment for chiropractic services is overdue if it is not paid within 30 days after the insurer receives documentation of the services provided unless, within those 30 days, the insurer provides a written statement to the insured that, on the basis of an independent evaluation, the insurer restricts or terminates the insured's coverage for the treatment, and the restriction results in the patient being liable for payment. Specify that, if an existing policy, plan or contract is inconsistent with this provision, the provision would first apply to the policy, plan or contract on the day on which the policy, plan or contract is terminated or renewed, whichever occurs first.

Generally, under current law, insurance claims are considered overdue if they are not paid within 30 days, unless the insurer has reasonable proof to establish that the insurer is not responsible for the payment. Overdue payments are subject to 12% interest annually.

[Act 16 Sections: 3755g, 3760m and 9327(1c)]

25. PAYMENT OF CLAIMS THAT MAY BE PAYABLE UNDER WORKER'S COMPENSATION

Senate: Require an insurer that issues a health care plan to pay a claim covered under the health care plan that may be payable under worker's compensation, but has not yet been finally determined to be payable under worker's compensation, within 30 days after the insurer is furnished with written notice of the fact of a covered loss and the amount of the loss. Specify that any part or all of a claim that is not paid within 30 days of the written notice would be overdue.

Under current law, a payment is not considered overdue if the insurer has reasonable proof to establish that the insurer is not responsible for the payment. This provision would require an insurer to pay a claim within 30 days even if the claim may be payable under worker's compensation. Overdue payments bear simple interest at 12% per year.

Conference Committee/Legislature: Delete provision.